

12894

CERTIFICATE OF DEATH

12896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Centreville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Centreville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAUDE E ANDERSON</u>		4. DATE OF DEATH Month Day Year <u>Nov. 29 1958</u>	
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 16-1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>LODA ANDERSON</u>	
14. MOTHER'S MAIDEN NAME <u>ANNIE NEWNAM</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>MRS. JOHN KIMBLES CENTREVILLE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Organic heart disease</u> <u>4343</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 26</u> , 19 <u>58</u> , to <u>Nov 29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 29</u> , 19 <u>58</u> , and that death occurred at <u>Centerville Ind.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Henry Fisher</u> M.D.		DATE SIGNED <u>11-29-58</u>	
PHYSICIAN'S NAME (Type) <u>W. Henry Fisher</u>		<u>Centerville Ind.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12-1</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Church Hill Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Kane</u> ADDRESS <u>Church Hill, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 3 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>

12895

CERTIFICATE OF DEATH

Reg. Dist. No.

12897

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>E</u> Middle <u>Fisher</u> Last				4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/22/1918</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Clara Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-01-0897</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute edema of lungs due to left heart failure</u> 2 hours <u>480X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Influenza a Nov. 20, 1958. bronchopneumonia Nov. 24, 1958.</u> DUE TO (c) <u>Arteriosclerosis, general + coronary Several years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>th</u>	
20f. (City or town) <u>th</u> (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 20</u> , 19 <u>58</u> , to <u>Nov. 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 26</u> , 19 <u>58</u> , and that death occurred at <u>6:15</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodor Sattelmair</u> M.D.				ADDRESS (Street, city or town, state) <u>Stevensville</u> DATE SIGNED <u>Nov. 26, 1958</u>			
PHYSICIAN'S NAME (Type) <u>THEODOR SATTELMAYER</u>				<u>STEVENSVILLE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>11-30-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Darkiel, Easton, md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>DEC 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12896

CERTIFICATE OF DEATH

12898

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Roberts</u>				c. LENGTH OF STAY IN 1b <u>X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Roberts</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>R.</u> Last <u>Goldsborough</u>				4. DATE OF DEATH Month <u>November</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 2, 1871</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>George Goldsborough--Church Hill, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. j. p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>58</u> to <u>Nov 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 3</u> , 19 <u>58</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Henry Fisher</u> M.D.		ADDRESS (Street, city or town, state) <u>Centreville Md.</u>			DATE SIGNED <u>11/7-58</u>		
PHYSICIAN'S NAME (Type) <u>W. Henry Fisher</u>		<u>Centreville, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 8</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Barclay Colored</u>	22d. LOCATION (City, town, or county) <u>Barclay Maryland</u>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>			ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. ...</u>	

CERTIFICATE OF DEATH

12888

<p>1. Name of deceased: George and Josephine - Church Hill, Md.</p>		<p>2. Date of death: 1910</p>	
<p>3. Place of death: Home</p>		<p>4. Cause of death: Heart</p>	
<p>5. Age at death: 70</p>		<p>6. Sex: Male</p>	
<p>7. Race: White</p>		<p>8. Religion: Methodist</p>	
<p>9. Occupation: Farmer</p>		<p>10. Education: High School</p>	
<p>11. Marital status: Married</p>		<p>12. Date of marriage: 1880</p>	
<p>13. Name of spouse: Josephine</p>		<p>14. Name of father: John</p>	
<p>15. Name of mother: Mary</p>		<p>16. Name of birthplace: Virginia</p>	
<p>17. Name of residence: Church Hill, Md.</p>		<p>18. Name of physician: Dr. J. H. Smith</p>	
<p>19. Name of undertaker: W. H. Jones</p>		<p>20. Name of funeral home: W. H. Jones</p>	
<p>21. Name of cemetery: Greenwood</p>		<p>22. Name of burial place: Greenwood</p>	
<p>23. Name of interment: Greenwood</p>		<p>24. Name of monument: Greenwood</p>	
<p>25. Name of monument: Greenwood</p>		<p>26. Name of monument: Greenwood</p>	
<p>27. Name of monument: Greenwood</p>		<p>28. Name of monument: Greenwood</p>	
<p>29. Name of monument: Greenwood</p>		<p>30. Name of monument: Greenwood</p>	
<p>31. Name of monument: Greenwood</p>		<p>32. Name of monument: Greenwood</p>	
<p>33. Name of monument: Greenwood</p>		<p>34. Name of monument: Greenwood</p>	
<p>35. Name of monument: Greenwood</p>		<p>36. Name of monument: Greenwood</p>	
<p>37. Name of monument: Greenwood</p>		<p>38. Name of monument: Greenwood</p>	
<p>39. Name of monument: Greenwood</p>		<p>40. Name of monument: Greenwood</p>	
<p>41. Name of monument: Greenwood</p>		<p>42. Name of monument: Greenwood</p>	
<p>43. Name of monument: Greenwood</p>		<p>44. Name of monument: Greenwood</p>	
<p>45. Name of monument: Greenwood</p>		<p>46. Name of monument: Greenwood</p>	
<p>47. Name of monument: Greenwood</p>		<p>48. Name of monument: Greenwood</p>	
<p>49. Name of monument: Greenwood</p>		<p>50. Name of monument: Greenwood</p>	
<p>51. Name of monument: Greenwood</p>		<p>52. Name of monument: Greenwood</p>	
<p>53. Name of monument: Greenwood</p>		<p>54. Name of monument: Greenwood</p>	
<p>55. Name of monument: Greenwood</p>		<p>56. Name of monument: Greenwood</p>	
<p>57. Name of monument: Greenwood</p>		<p>58. Name of monument: Greenwood</p>	
<p>59. Name of monument: Greenwood</p>		<p>60. Name of monument: Greenwood</p>	
<p>61. Name of monument: Greenwood</p>		<p>62. Name of monument: Greenwood</p>	
<p>63. Name of monument: Greenwood</p>		<p>64. Name of monument: Greenwood</p>	
<p>65. Name of monument: Greenwood</p>		<p>66. Name of monument: Greenwood</p>	
<p>67. Name of monument: Greenwood</p>		<p>68. Name of monument: Greenwood</p>	
<p>69. Name of monument: Greenwood</p>		<p>70. Name of monument: Greenwood</p>	
<p>71. Name of monument: Greenwood</p>		<p>72. Name of monument: Greenwood</p>	
<p>73. Name of monument: Greenwood</p>		<p>74. Name of monument: Greenwood</p>	
<p>75. Name of monument: Greenwood</p>		<p>76. Name of monument: Greenwood</p>	
<p>77. Name of monument: Greenwood</p>		<p>78. Name of monument: Greenwood</p>	
<p>79. Name of monument: Greenwood</p>		<p>80. Name of monument: Greenwood</p>	
<p>81. Name of monument: Greenwood</p>		<p>82. Name of monument: Greenwood</p>	
<p>83. Name of monument: Greenwood</p>		<p>84. Name of monument: Greenwood</p>	
<p>85. Name of monument: Greenwood</p>		<p>86. Name of monument: Greenwood</p>	
<p>87. Name of monument: Greenwood</p>		<p>88. Name of monument: Greenwood</p>	
<p>89. Name of monument: Greenwood</p>		<p>90. Name of monument: Greenwood</p>	
<p>91. Name of monument: Greenwood</p>		<p>92. Name of monument: Greenwood</p>	
<p>93. Name of monument: Greenwood</p>		<p>94. Name of monument: Greenwood</p>	
<p>95. Name of monument: Greenwood</p>		<p>96. Name of monument: Greenwood</p>	
<p>97. Name of monument: Greenwood</p>		<p>98. Name of monument: Greenwood</p>	
<p>99. Name of monument: Greenwood</p>		<p>100. Name of monument: Greenwood</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12897 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12899

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Francis Harold Griffith</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Oct 23 - 1958</u>		9. AGE (In years last birthday) yrs. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Chesterton Ind. Kent.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Francis Harold Griffin</u>				14. MOTHER'S MAIDEN NAME <u>Gladys Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mother</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>W. Henry Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>W. HENRY FISHER</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11/26/58</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-26</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>		22d. LOCATION (City, town, or county) _____ (State) <u>Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				ADDRESS <u>Church Hill, Ind.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

2072201XV6

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

Item 20 Film 235 11-18-58 ans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12898 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12900

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Tao</u> First Middle Last		4. DATE OF DEATH <u>Nov</u> Month Day Year <u>10</u> <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>cao</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov 22-1910</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cook</u>	
11. BIRTHPLACE (State or foreign country) <u>Centerville MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Rachert Standy</u>		14. MOTHER'S MAIDEN NAME <u>Wolmar Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	
17. INFORMANT <u>Julia King - Centerville MD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>916.0 Suffocation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Set his bed afire from cigarette</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) (County) (State) <u>QA</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W HENRY FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov-13-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chestnutfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Fisher</u> ADDRESS <u>Centerville MD</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 14 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hall</u>	

DATE SIGNED
11/13-58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12899 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12899 CERTIFICATE OF DEATH

12901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANKLIN</u> Middle <u>WILSON</u> Last <u>MESSICK</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Distributor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>oil</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Kendall Messick</u>		14. MOTHER'S MAIDEN NAME <u>Emma Sherwood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Douglas Messick</u> Address <u>Queen Anne, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery disease</u> DUE TO <u>HCKD</u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>4403</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>55</u> , to <u>Nov. 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 8</u> , 19 <u>58</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Kurt Lederer</u> M.D.		ADDRESS (Street, city or town, state) <u>QUEEN ANNE</u> DATE SIGNED <u>11/19</u>	
PHYSICIAN'S NAME (Type) <u>KURT LEDERER</u>		<u>MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 20, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Hillsboro, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Wannerban Dutton, Md.</u> ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>OV 24 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		45		M		W		1875		NEW YORK		NEW YORK		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
100 N. BROAD ST.		LABORER		HEART DISEASE		2 WEEKS		JAN. 10, 1920		NEW YORK		NEW YORK		NEW YORK	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE	
JAMES J. JONES		MARY J. JONES		ANNE J. JONES		JOHN J. JONES		HIGH SCHOOL		CATHOLIC		DEMOCRAT		NONE	
DATE OF INTERVIEW		BY		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE	
JAN. 10, 1920		J. J. JONES		JAMES J. JONES		MARY J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	

12900

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Starr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural Starr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>HATTIE</u> Middle <u>MILES</u> Last <u>MILES</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 28, 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John McMillen</u>		14. MOTHER'S MAIDEN NAME <u>Sela Boyles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Frank Miles</u>		Address <u>Captreville Ind.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Passive Cardiac Failure</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic Heart Disease</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>Longer</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAR. 1</u> , 1953, to <u>NOV. 15</u> , 1958, that I last saw the deceased alive on <u>Nov. 14</u> , 1958, and that death occurred at <u>5:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>MAPLE AVE</u> DATE SIGNED <u>11-15-58</u> ACTUAL SIGNATURE <u>Robert H. Wright</u> M.D. <u>MAPLE AVE</u> PHYSICIAN'S NAME (Type) <u>ROBERT H. WRIGHT M.D. GREENSBORO MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 17, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oysterfield</u>	22d. LOCATION (City, town, or county) (State) <u>Captreville Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Moore</u>		24a. REC'D BY REGISTRAR <u>NOV 19 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12901
 CERTIFICATE OF DEATH

14183

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x chester</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D.</u>				d. STREET ADDRESS <u>1 R.F.D.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Noah</u> Middle <u>Peters</u> Last <u>Peters</u>				4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-11-64</u>	
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Lucinda Peters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>54</u> , to <u>Nov</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 23</u> , 19 <u>58</u> , and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.				ADDRESS (Street, city or town, state) <u>Queen Anne, Md.</u> DATE SIGNED <u>12/1/58</u>			
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chester Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Hoskell</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12903

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Lisen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>	
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Waeter Herman Radeloff</u>		4. DATE OF DEATH <u>md</u> Month <u>3</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 29-1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Day work</u>	
11. BIRTHPLACE (State or foreign country) <u>Stevensville md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John Radeloff</u>		14. MOTHER'S MAIDEN NAME <u>Anna Elm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>22-30 09-1331</u>	
17. INFORMANT <u>Mrs Ray Radeloff-Grasonville Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. HENRY FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 6-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Fisher</u>		ADDRESS <u>Barton Bros. Centerville Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 6 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12302

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12302

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	
SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Jan 15, 1920</i>		PLACE OF DEATH <i>Home</i>	
CITY <i>Boston</i>		COUNTY <i>Suffolk</i>	
MANNER OF DEATH <i>Natural</i>		CAUSE OF DEATH <i>Myocardial Infarction</i>	
DISEASE OR INJURY <i>Coronary Artery Disease</i>		IMMEDIATE CAUSE OF DEATH <i>Thrombosis of Coronary Artery</i>	
PREVIOUS ILLNESS <i>None</i>		TREATMENT <i>None</i>	
SIGNATURE OF EXAMINER <i>Dr. J. A. Smith</i>		DATE <i>Jan 15, 1920</i>	
SIGNATURE OF NEXT OF KIN <i>John Doe</i>		DATE <i>Jan 15, 1920</i>	
SIGNATURE OF WITNESS <i>John Doe</i>		DATE <i>Jan 15, 1920</i>	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12904

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYland</u> b. COUNTY <u>Talbot Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Alexander</u> First <u>Watson</u> Middle <u></u> Last		4. DATE OF DEATH <u>11</u> Month <u>28</u> Day <u>1958</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12/96</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Watson</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Frazier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Carrah Watson, Chester, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Chester Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell, Eton, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DEC 12 '58</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		10/15/1918		Home	
Cause of Death		Disease		Symptoms		Manner of Death		Occupation		Education	
Heart Disease		Myocardial Infarction		Chest Pain, Shortness of Breath		Natural		Farmer		High School	
Time of Death		Place of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness	
10:30 AM		Home		[Signature]		[Signature]		[Signature]		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12905

CERTIFICATE OF DEATH

12905

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>				c. LENGTH OF STAY IN 1b <u>25 yrs -</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SARA</u> Middle <u>STEVENS</u> Last <u>WHALEY</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 13 - 1902</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Stevensville Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Clayland Stevens</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Ralph L. Whaley</u> Address <u>Queenstown Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Transitional cell epithelioma of urinary bladder</u> <u>181.0</u> DUE TO <u>with metastases in pelvis & intestines</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>urethrony by developrosis & kidney</u> DUE TO <u>kidney of stone & kidney</u> 1944 (c) <u>blood stream metastases</u> 1948 INTERVAL BETWEEN ONSET AND DEATH <u>1955</u> <u>1957</u> <u>1941</u> <u>1948</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>nephrectomy left kidney 25 years ago TB?</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ph</u>	
20f. (City or town) <u>Ph</u>				(County) <u> </u>		(State) <u> </u>	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>36</u> , to <u>Nov. 19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 19</u> , 19 <u>58</u> , and that death occurred at <u>11 55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> ADDRESS (Street, city or town, state) <u>Stevensville Md</u>				DATE SIGNED <u>Nov. 21, 1958</u>			
PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAIER STEVENSVILLE, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 22-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Howard Burtner</u> ADDRESS <u>Burtner Centerville Md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12906

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Starr</u>				c. LENGTH OF STAY IN 1b <u>7 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe (Rural)</u> 20x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Laura</u> First <u>Ross</u> Middle <u>Willis</u> Last				4. DATE OF DEATH <u>Nov</u> Month <u>7</u> Day <u>1958</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1867</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Talbot Co. Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Anthony Phillip Ross</u>			
14. MOTHER'S MAIDEN NAME <u>Laura Woodland</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs. Catherine Covington</u> Address <u>Starr Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Organic Heart disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Aug 15</u> , 19 <u>58</u> , to <u>Nov 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Henry Fisher</u> M.D. <u>Centerville Md</u>				DATE SIGNED <u>11/12/58</u>			
PHYSICIAN'S NAME (Type) <u>W Henry Fisher</u> <u>Centerville Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Willis Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>W. Trappe Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Lewman</u> ADDRESS <u>Easton Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

NEW JERSEY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
Items 8, 9 Film G235 11-12-58 et
12907
CERTIFICATE OF DEATH

12907

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Q.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barclay</u> adult life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barclay</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rfd. # 1 Box 12</u>				e. STREET ADDRESS <u>RFD # 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph H. Wilson</u>				4. DATE OF DEATH Month <u>November</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1886</u> <u>Oct. 3, 1886</u>	
9. AGE (In years last birthday) <u>71 1/2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Perry Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Frances Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Blanche Johnson Wilson</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epileptic seizure</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>4 years</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-21</u> 19 <u>58</u> , to <u>11-3</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 17</u> 19 <u>58</u> , and that death occurred at <u>11:4</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Kowalski</u> M.D.				ADDRESS (Street, city or town, state) <u>MILLINGTON MD</u> DATE SIGNED <u>11-4-58</u>			
PHYSICIAN'S NAME (Type) <u>G. E. Z. KORALINSKI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 7, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Barclay Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Barclay, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Waller</u> ADDRESS <u>Chestertown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1903

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH		5. PLACE OF DEATH	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN		10. SIGNATURE OF REGISTRAR	
11. PLACE OF BIRTH		12. DATE OF BIRTH		13. PLACE OF DEATH		14. DATE OF DEATH		15. PLACE OF DEATH	
16. PLACE OF BIRTH		17. DATE OF BIRTH		18. PLACE OF DEATH		19. DATE OF DEATH		20. PLACE OF DEATH	
21. PLACE OF BIRTH		22. DATE OF BIRTH		23. PLACE OF DEATH		24. DATE OF DEATH		25. PLACE OF DEATH	
26. PLACE OF BIRTH		27. DATE OF BIRTH		28. PLACE OF DEATH		29. DATE OF DEATH		30. PLACE OF DEATH	
31. PLACE OF BIRTH		32. DATE OF BIRTH		33. PLACE OF DEATH		34. DATE OF DEATH		35. PLACE OF DEATH	
36. PLACE OF BIRTH		37. DATE OF BIRTH		38. PLACE OF DEATH		39. DATE OF DEATH		40. PLACE OF DEATH	
41. PLACE OF BIRTH		42. DATE OF BIRTH		43. PLACE OF DEATH		44. DATE OF DEATH		45. PLACE OF DEATH	
46. PLACE OF BIRTH		47. DATE OF BIRTH		48. PLACE OF DEATH		49. DATE OF DEATH		50. PLACE OF DEATH	
51. PLACE OF BIRTH		52. DATE OF BIRTH		53. PLACE OF DEATH		54. DATE OF DEATH		55. PLACE OF DEATH	
56. PLACE OF BIRTH		57. DATE OF BIRTH		58. PLACE OF DEATH		59. DATE OF DEATH		60. PLACE OF DEATH	
61. PLACE OF BIRTH		62. DATE OF BIRTH		63. PLACE OF DEATH		64. DATE OF DEATH		65. PLACE OF DEATH	
66. PLACE OF BIRTH		67. DATE OF BIRTH		68. PLACE OF DEATH		69. DATE OF DEATH		70. PLACE OF DEATH	
71. PLACE OF BIRTH		72. DATE OF BIRTH		73. PLACE OF DEATH		74. DATE OF DEATH		75. PLACE OF DEATH	
76. PLACE OF BIRTH		77. DATE OF BIRTH		78. PLACE OF DEATH		79. DATE OF DEATH		80. PLACE OF DEATH	
81. PLACE OF BIRTH		82. DATE OF BIRTH		83. PLACE OF DEATH		84. DATE OF DEATH		85. PLACE OF DEATH	
86. PLACE OF BIRTH		87. DATE OF BIRTH		88. PLACE OF DEATH		89. DATE OF DEATH		90. PLACE OF DEATH	
91. PLACE OF BIRTH		92. DATE OF BIRTH		93. PLACE OF DEATH		94. DATE OF DEATH		95. PLACE OF DEATH	
96. PLACE OF BIRTH		97. DATE OF BIRTH		98. PLACE OF DEATH		99. DATE OF DEATH		100. PLACE OF DEATH	

MAINE STATE DEPARTMENT OF HEALTH

